County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

September 9, 2008

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

MEDICAL, DENTAL, LIFE INSURANCE, AND DISABILITY PLANS FOR 2009 (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Recommendation to approve 1) medical, dental, life and disability plans premium rates and benefit changes for represented and non-represented employees; and 2) appropriate agreements and amendments for County sponsored health, dental, and life insurance plans.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve proposed premium rates for County sponsored plans as follows: (a) medical and dental rates for represented employees for the period January 1, 2009 through December 31, 2009, as shown in Exhibit I, (b) medical and dental rates for non-represented employees for the period January 1, 2009 through December 31, 2009, as shown in Exhibit II; (c) optional group term life and dependent life insurance rates for represented employees for the period January 1, 2009 through December 31, 2010, as shown in Exhibit III; (d) survivor income benefit (SIB) rates for non-represented employees for the period January 1, 2009 through December 31, 2010, as shown in Exhibit III; and (e) rates for Short-Term Disability (STD), Long-Term Disability (LTD), and LTD Health Insurance plans, as shown in Exhibit IV.

2. Instruct the County Counsel to review and approve as to form the appropriate agreements with Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company (Blue Cross), Connecticut General Life Insurance Company and CIGNA Healthcare of California, Inc. (CIGNA), Kaiser Foundation Health Plan, Inc. (Kaiser), Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Mid-Atlantic), PacifiCare of California and PacifiCare Life and Health (PacifiCare), and Delta Dental Plan (Delta Dental), for the period January 1, 2009 through December 31, 2009, and instruct the Chair to sign such agreements.

3. Instruct the County Counsel to review and approve as to form appropriate amendments with SafeGuard Health Plans, Inc. (SafeGuard) for the period January 1, 2009 through December 31, 2009, and Life Insurance of North America (LINA) and Metropolitan Life Insurance Company (MetLife) for the period January 1, 2009 through December 31, 2010, and instruct the Chair to sign such amendments.

4. Approve proposed premium rates and benefit coverage changes for the following union sponsored plans, as shown in Exhibit V, for the period January 1, 2009 through December 31, 2009: The Association for Los Angeles Deputy Sheriffs, Inc. (ALADS), the California Association of Professional Employees (CAPE), and the Los Angeles County Fire Fighters Local 1014 Health and Welfare Plan.

5. Approve a proposed increase in the Tobacco User Premium from $10 to $20 per month for non-represented employees.

6. Approve an adjustment in the minimum County contribution under the MegaFlex and Flexible Benefit Plans from $987 and $735 per month, respectively, to $1,078 and $809 per month, respectively, to be initially reflected on the January 15, 2009 pay warrants.

7. Instruct the Auditor-Controller to make all payroll system changes necessary to implement the changes recommended herein to ensure that all changes in premium rates are first reflected on pay warrants issued on January 15, 2009.

8. Instruct the County Counsel to prepare the ordinances necessary to amend Title 5 of the Los Angeles County Code to implement the recommended changes.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Purpose

The County maintains employee health, dental, group life, and other insurance programs to provide benefits that promote the effectiveness, health, and welfare of its workforce. The current agreements for all County and union sponsored medical, dental and life insurance plans end on December 31, 2008. The purpose of the recommendations contained in this letter is to implement negotiated agreements with carriers to continue existing benefits and to adopt benefit changes for the 2009 calendar year.

Justification

Overall Premium Negotiation Process and Results

County Sponsored Plans in General. The recommendations in Exhibits I, II, III, and IV regarding the County sponsored plans are the result of intensive negotiations between the health, dental, and life insurance carriers and the County negotiating team consisting of representatives of the Chief Executive Office (CEO), Director of Personnel (DOP), and the County's group insurance consultant, Mercer Consulting (Mercer). For County sponsored plans whose benefits are governed by Fringe Benefit Memoranda of Understanding (MOU) with SEIU Local 721 (Local 721) and the Coalition of County Unions (CCU), the unions' benefit consultants have had input into the insurance carrier negotiation process.

Mercer's opinion is that the County sponsored plan carriers' final negotiated rates are justified. Mercer's opinion and the supporting due diligence is documented in Attachments A and B.

In general, County medical and dental plans are rated by carriers based on the cost of claims, claims trend and administration costs, taking into account the health risk of, and the utilization of health care by County employees and their covered dependents. In 2008, there continues to be an ongoing pattern of increases in hospital and pharmaceutical costs driving medical insurance costs upwards at a rate estimated by Mercer at 9% in Southern California.

The County sponsored medical plan rates recommended in this letter, averaging 8.5% for represented employees and 8.9% for non-represented employees, are slightly less than the Southern California average. The underlying dental trend is more moderate. Life insurance rates are guaranteed through 2010; however, because the County's

experience over the last year has been favorable, the premiums for optional term life insurance and dependent life insurance for represented employees will be reduced 10% for 2009 and 2010.

County Approved Union Sponsored Plans in General. The premium and benefit recommendations in Exhibit V regarding County approved union sponsored health plans were negotiated by the sponsoring unions and evaluated by the CEO and DOP pursuant to the relevant provisions of the CCU Fringe MOU and County Code. The joint CEO and DOP recommendations are provided later in this report.

Renewal Policy and Process. In accordance with the County policy, the County negotiating team requires all carriers to justify rates and support proposed contract terms for the upcoming plan year. The rate renewal process for 2009 (documented in Attachments A and B) is designed to encourage full involvement and transparency among all County, union and carrier stakeholders. The process involves production of data by carriers as needed, identification, in depth analysis and evaluation of all material underwriting issues in carrier proposals and documentation of due diligence and financial results. All parties fully complied with the process.

Overall Results. Attachment C is a high level summary of carrier negotiation results that compares the estimated actual total premiums from initial carrier premium quotes for 2009 with the final result after performance guarantee review, challenges to carrier underwriting, benefit changes, and negotiation. Summary reasons for the negotiated reductions are given.

Total 2009 premiums to be paid to health, dental, group life, and other insurance plan carriers are estimated to be $882 million which represents $738 million for County sponsored plans and $144 million for union sponsored plans. This is an increase of $65 million or 8.1% over 2008.

Total savings from initial 2009 carrier proposals is $5.4 million. Of that, $4.4 million are negotiated savings from 2009 carrier proposals, and $1.0 million is from performance guarantee refunds and rate credits.

Attachment C also shows the percentage increase for each carrier by cafeteria plan as well as the total increase for County sponsored health, dental, group life and other insurance programs. The increase in medical plan premiums estimated to be paid to health carriers during 2009 will range from -3.7 % to 12.7% for an average of 8.6%,

which is lower than the expected average projected Southern California increase of 9%. The overall increase for dental plans will be 9.1% which includes benefit enhancements that are employee paid. Optional and dependent life insurance rates for represented employees for 2009 will decrease by 10% from 2008 levels.

2009 Premium Rates Recommended for Adoption

Recommended Rates. County and union sponsored health, dental, group life and other insurance rates recommended for adoption are shown in Exhibits I through V. Unless otherwise noted in this letter, the rates support existing benefits enabled by the applicable MOU, or County Code provision. The rates shown in these Exhibits are the monthly prices that employees will pay from County cafeteria plan contributions from their own resources after County subsidies are subtracted from negotiated carrier premium rates paid to carriers. For this reason, percentage increases in premium rates to be charged to employees as shown in the Exhibits, in many cases, may differ from the negotiated increases in premium to be paid to carriers as reported in the body of this letter and in Attachment C.

Union Concurrence. Local 721 and management representatives voted in the Labor-Management Benefit Administration Committee (BAC) to recommend the premium rates and benefit coverage changes for employees represented by Local 721. The CCU and management representatives in the Labor-Management Employee Benefits Administration Committee (EBAC) voted to recommend the premium rates for employees represented by the CCU.

Implementation of Strategic Plan Goals

The recommended actions are consistent with the principles of the Countywide Strategic Plan by promoting the well being of County employees and their families by offering comprehensive employee benefits.

FISCAL IMPACT/FINANCING

Each cafeteria plan, including represented employee plans provided by MOUs with County unions, provides for a County contribution and, in some cases, an additional subsidy to help pay the cost of insurance benefits. The current County contributions and applicable subsidies for employee benefits mentioned in this letter, or changed contributions, or subsidies recommended herein are included in the Fiscal Year 2008-2009 budget. Employees pay for additional costs above and beyond the County contributions and subsidies through payroll deductions.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

The general facts concerning 2009 premium rate and benefit adjustments for County sponsored plans affecting both represented and non-represented employees are stated in this section. The details of each carrier's County sponsored medical, dental, group life, and other insurance plan proposal, Mercer's evaluation, and Mercer's opinion concerning their justification and terms of offer are given in Attachments A and B. Unless otherwise specified, the term of offer is one year.

Represented Employees

Medical Plan Benefit Changes Affecting Represented Employees

For 2009, Local 721 has elected to waive co-pays for preventive care for employees in Kaiser and PacifiCare medical plans. The cost of waiving co-pays for preventive care is .65% of premium for Kaiser and .09% for PacifiCare. Preventive co-pays include physical examinations, immunizations, mammograms, etc. The goal of waving co-pays is to encourage employees to seek preventive care.

The CCU also considered waiving co-pays for preventive care. The cost of waiving co-pays is .65% of premium for Kaiser, while Cigna agreed to waive preventive co-pays at no increase in premium in 2009. The CCU agreed to Cigna's proposal, but declined Kaiser's offer since Kaiser included a premium increase in their proposal. While the CCU has requested that the co-pay waiver be implemented for CIGNA only, we do not support that change. We do not recommend separate plan designs for competing HMO's within the same CCU Choices Plan population. Mercer concurs with this stance.

Medical Plan Rates Affecting Represented Employees

CIGNA Rates for 2009

CIGNA provides two different plans to employees represented by the CCU. One is an HMO and the other is a point of service (POS) plan. The 2009 negotiated contract rates for all CIGNA plans will decrease 3.7% after excess reserves in the CIGNA Premium Stabilization Reserve (PSR) are applied to the premium.

Mercer's opinion justifying Cigna's 2009 rates and supporting a transfer of excess reserves from the PSR to reduce premium is included in Attachment A.

Kaiser Rates for 2009

Kaiser's 2009 rates will increase by 7.9% for the CCU and 9.7% for the Local 721 plan. The rates for the Local 721 plan include the change in plan design described above. The lower renewal for the CCU is reflective of the higher starting point for 2008, which included a 1.5% risk load that has been removed for 2009. The rates also reflect a credit for a performance penalty.

This year Kaiser improved data reporting and provided a much more detailed analysis of the renewal drivers. We will continue to monitor emerging experience and any rating gains and losses in the next few years.

As we continue to implement a wellness initiative for County employees as part of the Cost Mitigation Goals and Objectives (CMGOs) and beyond, the County and Kaiser are sharing in the costs of the program. Certain elements of the wellness program are included in the rates. Any funds not used will be refunded in the following year. Kaiser is also funding and absorbing the costs of additional elements of the wellness program.

Mercer's opinion certifying Kaiser's 2009 rates as justified is included in Attachment A.

PacifiCare Rates for 2009: PacifiCare provides two fully insured plans to employees represented by Local 721. An HMO and a preferred provider organization (PPO) plan. The 2009 negotiated premium rates for the HMO plan will increase 10.6% and the PPO plan will increase 17.9% for an overall increase of 10.9%. Mercer's opinion justifying PacifiCare's 2009 rates and recommendation is included in Attachment A.

Union Sponsored Plan Benefit Changes and Rates for 2009

Premiums for County approved union sponsored plans will also increase for 2009. The estimated increase in premiums paid to carriers in 2009 on behalf of the union sponsored plans is approximately $11.9 million. Proposed 2009 premium increases to be paid to carriers and benefit changes for the ALADS, CAPE, and Los Angeles County Local 1014 Fire Fighters Plans are summarized below:

Summary of Union Sponsored Plan Changes for 2009

Union Sponsor	Average Increase in Rates to be Paid to Carrier on Behalf of Plan Sponsor	Requested Benefit Changes
ALADS	**8.4%**	• Increase Lifetime Maximum benefit to $5,000,000.
		• Change Mental Health/Substance Abuse provider and benefits as outlined in Exhibit V, Enclosure 1.
CAPE	**10.4%**	• Add coverage for Immunizations and Periodic Health Exams for Classic and Lite, PPO and Out-of-Network: o $20 copay for Classic plan under PPO. o $25 copay for Lite plan under PPO. o 60% after deductible under Out-of-Network.
		• Reduce generic prescription drug copays for Classic and Lite plans under PPO tier to $5 generic and $10 for 90-day generic mail order.
		• Add coverage for annual eye exams under Classic and Lite PPO and Out-of-Network tiers for non-MES providers.
		• Reduce office visit copay, add vision care coverage, and increase carrier coinsurance for the COBRA PPO plan as outlined in Exhibit V, Enclosure 2.
Local 1014	**8.5%**	• Increase In-Network coinsurance to 90%.
		• Increase individual lifetime maximum to $4,000,000.
		• Increase chiropractic benefits as outlined in Exhibit V, Enclosure 3.
		• Include coverage for shingles vaccination.
		• Hearing aids coverage for children through age 19, $1,000 per ear every three years.
		• Increase LASIK benefit per eye to $1,500 @ 80%.
		• Enhance VSP benefit to reimburse frames as outlined in Exhibit V, Enclosure 3.

The subsidized rates to be paid by employees enrolled in union sponsored plans are summarized in Exhibit V. The complete list of carrier benefit changes, upon which the 2009 rates are based, are documented in the union request letters attached to Exhibit V. We have reviewed the changes for all three plans and support them.

Dental Plan Changes Affecting Represented Employees

The recommended employee contribution rates for County sponsored represented employee dental plans are summarized in Exhibit I. The 2009 dental rates shown in Exhibit I are the rates quoted by the carriers for represented employees, except that in the case of Delta Dental, the rates were reduced by the 2009 subsidies previously negotiated with the unions and approved by your Board.

The following employee paid benefits enhancements were agreed to by Local 721 for the Delta Dental PPO:

- Increase annual plan maximum to $1,750 across all three network tiers
- Add orthodontia coverage for adults and children with a 50% coinsurance subject to a $1,200 lifetime maximum
- Add coverage for dental implants with 50% coinsurance subject to the annual plan maximum
- Allow a third teeth cleaning if medically recommended

The Delta Dental PPO contract rates for Local 721 will increase by 16.9%, including the benefit enhancements. The actual rate increases for 2009 will be lower at 15.1%, as they include a stabilization reserve credit. The rates are guaranteed through December 31, 2010.

Currently, the Delta Dental PPO for the CCU and non-represented populations are rated together. Beginning in 2010, the risk pool for the CCU and non-represented dental plan will be split and separate renewals will apply. Delta Dental proposed a 3.2% increase on the contract rates and no increase in the actual premium rates in 2009. Therefore, CCU employees in the Delta Dental PPO will not see a rate increase in 2009.

The CCU declined to accept any dental benefit changes with a cost impact for 2009.

The prepaid dental plan DeltaCare USA's rates will increase by 4.9% for both Local 721 and the CCU and are guaranteed for two years through December 31, 2010.

SafeGuard's contract rates are guaranteed through December 31, 2010. The actual rates for 2009 will differ slightly as they include a credit for 2007 performance guarantee penalties.

Life Insurance and Disability Programs for Represented Employees

Basic term life insurance and Accidental Death and Dismemberment (AD&D) rates for 2009 are the same as 2008 and are guaranteed through 2010. Optional group term life insurance and dependent life insurance rates will be reduced by 10% in 2009 and 2010 due to favorable experience. To support employees called to active military duty, CIGNA has agreed to allow an increase of life insurance by one level upon military activation.

Non-Represented Employees

Medical Plan Changes Affecting Non-Represented Employees

Non-represented employees who participate in the MegaFlex and Flexible Benefit Plans have a choice between Kaiser and four Blue Cross health plans, which include an HMO, POS, PPO, and a Catastrophic Plan. For 2009, we are recommending waiving co-pays for preventive care for employees in Kaiser and Blue Cross. Preventive co-pays include physical examinations, immunizations, mammograms, etc. The goal behind waving co-pays is to encourage employees to seek preventive care. The County cost of waving preventive co-pays will be offset from the tobacco user premium currently charged to non-represented employees. The current fee is $10 per month and will increase to $20 beginning in 2009. Any excess collected from this fee will be used to fund wellness programs.

The negotiated contract rates for Kaiser will increase 3.0%, while the average increase in contract rates for the Blue Cross HMO and Blue Cross indemnity plans (POS, PPO, and Catastrophic) will be 12.7%. In the past, we have averaged the Kaiser and Blue Cross adjustments for the non-represented employee population and we are recommending that we continue that practice in 2009. Therefore, overall non-represented health plan rates will increase by 8.9% in 2009.

In addition, we are also expanding the Vision Service Plan (VSP) network in the Blue Cross plans from the value network to the full provider network to increase the number of providers available to employees.

The 2009 negotiated contract rates for the Kaiser Mid-Atlantic plan, for a few CEO employees working in the Washington, DC area, is community rated and will increase 6.0% for 2009. The Mid-Atlantic plan has a standardized benefit plan design and will not include the preventive care benefit change.

Mercer recommends that the County accept the final 2009 renewals offered by Blue Cross and Kaiser. See Attachment B for their review and opinion.

We recommend that your Board continue the historical County practice of funding any difference between the negotiated contract cost of these plans and the contribution paid by the employees. The recommended employee contribution rates are summarized in Exhibit II.

Dental Plan Changes Affecting Non-represented Employees

The recommended employee contribution rates for County sponsored non-represented employee dental plans are summarized in Exhibit II. The Delta Dental PPO rates have been reduced by the 2009 County subsidies previously approved by your Board.

For the PPO plan, the CCU and non-represented populations are currently rated together. As noted previously in this letter, the County's risk pool for the CCU and non-represented populations will be split and separate renewals for each population will apply beginning in 2010. For 2009, there will be no increase in actual premium rates except for the increases required for the benefit improvements listed below. The required premium increases will be entirely paid by employee contributions. There will be no County cost associated with these changes:

- Increase the Delta Preferred option annual maximum to $1,750
- Add orthodontia coverage for adults and children with a 50% co-insurance subject to a $1,200 lifetime maximum
- Add coverage for dental implants with a 50% co-insurance subject to the annual maximum
- Allow a third covered teeth cleaning if medically recommended

The Delta Dental PPO plan contract rates will increase by 12.2%, which include the employee paid benefit enhancements for 2009. The actual rate increases will be lower at 9.2%, as they include a stabilization reserve credit.

The rates for the prepaid dental plan DeltaCare USA will increase by 4.9%, and are guaranteed for two years through December 31, 2010.

SafeGuard's contract rates are guaranteed through December 31, 2010. The actual rate for 2009 will be slightly lower due to a credit for 2007 performance guarantee penalties.

Life Insurance and Disability Programs

MetLife's rates for supplemental Group Universal Variable (GVUL) life insurance and the Dependent Life remain the same as 2008 and are guaranteed through December 31, 2010.

The contract rates for the MetLife survivor income benefit (SIB) are guaranteed through December 31, 2010. However, the actual rate to be paid by employees for the SIB will decrease by 10% in 2009 and 2010, due to a surplus reserve transferred to MetLife from the prior insurer, CIGNA. Any unspent amount at the end of 2010 will be refunded to the County or used as a credit for the renewal rate proposal for 2011. MetLife has also agreed for GVUL to allow an increase of life insurance by one level upon military activation.

There will be no changes in the cost of the Long-Term Disability (LTD) and Short-Term Disability (STD) rates for 2009.

Changes to the Minimum County Contribution Under the MegaFlex and Flexible Benefit Plans

Currently, non-represented employees covered by the MegaFlex and Flexible Benefit Plans currently receive a County contribution expressed as a percentage of salary, but not less than a minimum "floor" contribution of $987 per month under MegaFlex, and $735 per month under the Flexible Benefit Plan. For 2009, we recommend that the minimum contributions be increased to $1,078 for the MegaFlex Plan and $809 for the Flexible Benefit Plan, due to increased employee health and dental insurance costs. These adjustments would be initially reflected on the County pay warrants issued on January 15, 2009.

Upon adoption of the recommendations contained herein, the County Counsel will prepare the ordinances, including benefit plan amendments and contracts, necessary to implement the recommendations.

Respectfully submitted,

WILLIAM T FUJIOKA
Chief Executive Officer

WTF:SRH:DL
WGL:WW:df

Attachments (11)

c: Executive Officer, Board of Supervisors
Auditor-Controller
County Counsel
Department of Human Resources
SEIU Local 721
Coalition of County Unions
Mercer

COUNTY-SPONSORED
MEDICAL AND DENTAL INSURANCE PLANS
FOR REPRESENTED EMPLOYEES
CURRENT 2008 RATES AND PROPOSED 2009 RATES

Plan	Option	Coverage Category [a]	Current 2008 Rates[b]	Proposed 2009 Rates[b]	Percentage Change
CIGNA	Network HMO	1	$346.95	$334.14	-3.7%
Choices		2	$689.62	$663.96	-3.7%
		3	$794.28	$764.75	-3.7%
CIGNA	Network POS	1	$622.56	$599.57	-3.7%
Choices		2	$1,104.85	$1,063.86	-3.7%
		3	$1,159.08	$1,116.08	-3.7%
KAISER		1	$415.85	$448.77	7.9%
Choices		2	$826.26	$892.10	8.0%
		3	$959.33	$1,035.71	8.0%
KAISER		1	$387.68	$425.94	9.9%
Options		2	$778.36	$854.88	9.8%
		3	$902.34	$991.10	9.8%
PACIFICARE	HMO	1	$338.86	$375.43	10.8%
Options		2	$687.65	$761.52	10.7%
		3	$796.01	$881.59	10.8%
PACIFICARE	PPO	1	$894.80	$1,056.27	18.0%
Options		2	$1,810.13	$2,136.23	18.0%
		3	$2,096.82	$2,474.64	18.0%

[a] 1 = Employee only
2 = Employee + 1 Dependent
3 = Employee + 2 or more Dependents

[b] Rates reflect current negotiated County subsidies

COUNTY-SPONSORED
MEDICAL AND DENTAL INSURANCE PLANS
FOR REPRESENTED EMPLOYEES
CURRENT 2008 RATES AND PROPOSED 2009 RATES

Plan	Option	Coverage Category [a]	Current 2008 Rates[b]	Proposed 2009 Rates[b]	Percentage Change
DELTA DENTAL		1	$21.09	$21.09	0.0%
Choices		2	$35.20	$35.20	0.0%
		3	$52.62	$52.62	0.0%
DELTA DENTAL[c]		1	$31.66	$39.53	24.9%
Options		2	$52.80	$66.20	25.4%
		3	$79.29	$99.79	25.9%
DELTACARE USA[d]		1	$13.83	$14.51	4.9%
Choices & Options		2	$22.81	$23.93	4.9%
		3	$33.74	$35.40	4.9%
SAFEGUARD[e]		1	$10.19	$10.21	0.2%
Choices & Options		2	$19.70	$19.72	0.1%
		3	$25.70	$25.72	0.1%

[a] 1 = Employee only
2 = Employee + 1 Dependent
3 = Employee + 2 or more Dependents

[b] Rates reflect current negotiated County subsidy.

[c] Delta 2009 rates for Options are guaranteed through 2010.

[d] DeltaCare USA rates are guaranteed through 2010.

[e] SafeGuard Rates are guaranteed through 12/31/2010. SafeGuard rates for 2009 rates reflect a credit adjustment for 2007 performance guarantee penalties.

COUNTY-SPONSORED
MEDICAL AND DENTAL INSURANCE PLANS
FOR NON-REPRESENTED EMPLOYEES
CURRENT 2008 RATES AND PROPOSED 2009 RATES

Plan	Option	Coverage Category[a]	Current 2008 Rates[b]	Proposed 2009 Rates[b]	Percentage Change
BLUE CROSS	CaliforniaCare HMO	1	$227.85	$248.00	8.8%
		2	$445.66	$485.00	8.8%
		3	$467.48	$509.00	8.9%
		4	$528.67	$576.00	9.0%
BLUE CROSS	PLUS POS	1	$344.29	$375.00	8.9%
		2	$691.26	$753.00	8.9%
		3	$707.50	$770.00	8.8%
		4	$789.15	$859.00	8.9%
BLUE CROSS	Catastrophic	1	$176.23	$192.00	8.9%
		2	$353.60	$385.00	8.9%
		3	$359.06	$391.00	8.9%
		4	$415.29	$452.00	8.8%
BLUE CROSS	Prudent Buyer PPO	1	$439.11	$478.00	8.9%
		2	$806.19	$878.00	8.9%
		3	$837.19	$912.00	8.9%
		4	$969.96	$1,056.00	8.9%
KAISER Flex/Megaflex		1	$227.85	$248.00	8.8%
		2	$445.66	$485.00	8.8%
		3	$467.48	$509.00	8.9%
		4	$528.67	$576.00	9.0%
KAISER - MID-ATLANTIC		1	$227.85	$248.00	8.8%
		2	$445.66	$485.00	8.8%
		3	$467.48	$509.00	8.9%
		4	$528.67	$576.00	9.0%
DELTA DENTAL[c] Flex/Megaflex		1	$21.10	$25.05	18.7%
		2	$31.04	$38.42	23.8%
		3	$35.25	$42.36	20.2%
		4	$52.68	$63.36	20.3%
DELTACARE USA[d] Flex/Megaflex		1	$13.83	$14.51	4.9%
		2	$23.89	$25.07	4.9%
		3	$23.72	$24.89	4.9%
		4	$34.43	$36.13	4.9%
SAFEGUARD[e] Flex/Megaflex		1	$10.19	$10.21	0.2%
		2	$19.12	$19.14	0.1%
		3	$21.56	$21.58	0.1%
		4	$28.16	$28.18	0.1%

[a] 1 = Employee only
2 = Employee + Child(ren)
3 = Employee + Spouse
4 = Employee + Spouse + Chil(ren)

[b] Rates, where applicable, are net of County subsidy; except that the premium charged to an employee whose benefits are subject to COBRA is the carrier quoted rate plus an administrative charge as prescribed by COBRA.

[c] Delta Dental rates for 2009 reflect County subsidies.

[d] DeltaCare USA rates are guaranteed through 2010.

[e] SafeGuard Rates are guaranteed through 12/31/2010. SafeGuard rates for 2009 rates reflect a credit adjustment for 2007 performance guarantee penalties.

LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT AND SURVIVOR INCOME BENEFIT PROGRAMS CURRENT 2008 RATES AND PROPOSED 2009 RATES

	Monthly Cost per $1,000 of Insurance	
	2008[a]	**2009**[a]
COUNTY-PAID BASIC GROUP TERM-LIFE INSURANCE	$0.275	$0.275

OPTIONAL GROUP TERM LIFE INSURANCE FOR REPRESENTED EMPLOYEES

Employee: The monthly premium per $1,000 of insurance is based on the employee's age as shown in the following table:

Age	2008[a,b]	2009[a,b]
Less than 30	$0.047	$0.042
30-34	$0.080	$0.072
35-39	$0.090	$0.081
40-44	$0.100	$0.090
45-49	$0.150	$0.135
50-54	$0.230	$0.207
55-59	$0.430	$0.387
60-64	$0.660	$0.594
65-69	$0.942	$0.848
70 and over	$1.813	$1.630

Dependent Term Life Insurance:	**2008**[a]	**2009**[a]
Cost per month per $5,000 of coverage, no matter how many eligible dependents employee may have. Coverage is offered in increments of $5,000 up to $20,000. Dependent care coverage premium is charged to the employee.	$1.091	$0.982

[a] Rates are guaranteed through 12/31/2010.

[b] The County subsidizes 15% of the monthly premium.

LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT AND SURVIVOR INCOME BENEFIT PROGRAMS CURRENT 2008 RATES AND PROPOSED 2009 RATES

OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE - Cost per Month

	Current 2008 Rates*		Proposed 2009 Rates*	
Employee Coverage	Employee Only Plan G	Employee & Dependents Plan H	Employee Only Plan G	Employee & Dependents Plan H
$ 10,000	$0.21	$0.41	$0.21	$0.41
$ 25,000	$0.52	$1.02	$0.52	$1.02
$ 50,000	$1.05	$2.05	$1.05	$2.05
$100,000	$2.10	$4.10	$2.10	$4.10
$150,000	$3.15	$6.15	$3.15	$6.15
$200,000	$4.20	$8.20	$4.20	$8.20
$250,000	$5.25	$10.25	$5.25	$10.25
$300,000	$6.30	$12.30	$6.30	$12.30
$350,000	$7.35	$14.35	$7.35	$14.35

These rates apply regardless of employee's age. If Plan H is selected, all eligible dependents will be insured automatically.

* Rates are guaranteed through 12/31/2010.

LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT AND SURVIVOR INCOME BENEFIT PROGRAMS CURRENT 2008 RATES AND PROPOSED 2009 RATES

OPTIONAL GROUP VARIABLE UNIVERSAL LIFE INSURANCE FOR FLEX/MEGAFLEX PARTICIPANTS

Employee: The monthly premium per $1,000 of insurance is based on the employee's age as shown in the following table:

Age	Current 2008 Rate*	2009 Rate*	Age	Current 2008 Rate*	2009 Rate*
20-24	$0.045	$0.045	66	$0.826	$0.826
25-29	$0.056	$0.056	67	$0.879	$0.879
30-34	$0.065	$0.065	68	$0.979	$0.979
35-39	$0.067	$0.067	69	$1.088	$1.088
40	$0.078	$0.078	70	$1.197	$1.197
41-42	$0.079	$0.079	71	$1.323	$1.323
43	$0.088	$0.088	72	$1.469	$1.469
44	$0.100	$0.100	73	$1.613	$1.613
45	$0.111	$0.111	74	$1.786	$1.786
46	$0.121	$0.121	75	$1.968	$1.968
47	$0.132	$0.132	76**	$2.186	$2.186
48	$0.154	$0.154	77**	$2.476	$2.476
49	$0.164	$0.164	78**	$2.794	$2.794
50	$0.175	$0.175	79**	$3.148	$3.148
51	$0.197	$0.197	80**	$4.064	$4.064
52	$0.207	$0.207	81**	$4.690	$4.690
53	$0.228	$0.228	82**	$5.116	$5.116
54	$0.251	$0.251	83**	$5.579	$5.579
55	$0.284	$0.284	84**	$6.078	$6.078
56	$0.305	$0.305	85**	$6.631	$6.631
57	$0.338	$0.338	86**	$7.211	$7.211
58	$0.381	$0.381	87**	$7.846	$7.846
59	$0.425	$0.425	88**	$8.526	$8.526
60	$0.478	$0.478	89**	$9.225	$9.225
61	$0.538	$0.538	90**	$9.941	$9.941
62	$0.594	$0.594	91**	$10.694	$10.694
63	$0.639	$0.639	92**	$11.465	$11.465
64	$0.708	$0.708	93**	$12.263	$12.263
65	$0.736	$0.736	94**	$13.071	$13.071

* Rates were previously Board approved and are guaranteed through 12/31/2010.
Employee cost for Megaflex employees is half of actual premium. The County pays the other 50%.

** For employees age 76-94 who remain in County service, County will subsidize the difference between the employee's cost of coverage using the premiums for the employee's actual age and cost of coverage using age 75 rate.

LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT AND SURVIVOR INCOME BENEFIT PROGRAMS CURRENT 2008 RATES AND PROPOSED 2009 RATES

Dependent Term Life Insurance for Flex and Megaflex Participants

	2009 Rate*
Cost per month per $5,000 of dependent life coverage, up to $20,000.	1.24**

SURVIVOR INCOME BENEFIT - For Megaflex participants enrolled in Retirement Plan

	Current 2008 Rates*		Proposed 2009 Rates*	
Employee Age	Employee Cost** (25% Option)	Employee Cost** (50% Option)	Employee Cost** (25% Option)	Employee Cost** (50% Option)
Under 30	0.156%	0.300%	0.140%	0.270%
30 to 34	0.192%	0.396%	0.173%	0.356%
35 to 39	0.252%	0.516%	0.227%	0.464%
40 to 44	0.360%	0.708%	0.324%	0.637%
45 to 49	0.480%	0.960%	0.432%	0.864%
50 to 54	0.636%	1.272%	0.572%	1.145%
55 to 59	0.912%	1.836%	0.821%	1.653%
60 to 64	1.248%	2.496%	1.123%	2.246%
65 to 69	1.716%	3.432%	1.545%	3.089%
70 and over	3.048%	6.096%	2.743%	5.487%

* Rates are guaranteed through 12/31/2010.
** Employee Cost for MegaFlex is half of the actual premium. The County pays the other 50%.

SHORT-TERM DISABILITY, LONG-TERM DISABILITY AND LONG-TERM DISABILITY HEALTH INSURANCE CURRENT 2008 RATES AND PROPOSED 2009 RATES

MEGAFLEX SHORT-TERM DISABILITY PLAN

Employee Cost as a Percentage of Monthly Salary:

Current 2008 Rates			Proposed 2009 Rates		
Income Replacement	Waiting Period	Cost	Income Replacement	Waiting Period	Cost
70%	14 Days	0.000%	70%	14 Days	0.000%
100%*	7 Days	0.934%	100%*	7 Days	0.934%

* Reduced to 80% after 21 days

MEGAFLEX LONG-TERM DISABILITY PLAN

Employee Cost as a Percentage of Monthly Salary:

	Current 2008 Rates		Proposed 2009 Rates	
Income Replacement	Plan E + * Retirement Plan	All Other Plans	Plan E + * Retirement Plan	All Other Plans
40%	0.000%	0.040%	0.000%	0.040%
60%	0.117%	0.157%	0.117%	0.157%

* Plan E plus 5 more years of continuous service

SHORT-TERM DISABILITY, LONG-TERM DISABILITY AND LONG-TERM DISABILITY HEALTH INSURANCE CURRENT 2008 RATES AND PROPOSED 2009 RATES

LONG-TERM DISABILITY HEALTH INSURANCE - Cost per month

For Flex/MegaFlex Employees

Current 2008 Rate		Proposed 2009 Rate	
75 % Premium Payment	100 % Premium Payment	75 % Premium Payment	100 % Premium Payment
$0.00	$3.00	$0.00	$3.00

For Represented Employees

Current 2008 Rate		Proposed 2009 Rate	
75 % Premium Payment	100 % Premium Payment	75 % Premium Payment	100 % Premium Payment
$0.00	$3.00	$0.00	$3.00

UNION-SPONSORED
MEDICAL AND DENTAL INSURANCE PLANS
CURRENT 2008 RATES AND PROPOSED 2009 RATES

Plan	Option	Coverage Category[a]	Current 2008 Rates[b]	Proposed 2009 Rates[b]	Percentage Change
ALADS	Prudent Buyer Plan	1	$561.24	$601.37	7.2%
Blue Cross	Under Age 50	2	$1,094.81	$1,174.63	7.3%
		3	$1,257.21	$1,348.68	7.3%
ALADS	Prudent Buyer Plan	1	$561.24	$601.37	7.2%
Blue Cross	Age 50 and Over	2	$1,094.81	$1,174.63	7.3%
		3	$1,257.21	$1,348.68	7.3%
ALADS	CaliforniaCare	1	$360.68	$392.77	8.9%
Blue Cross	Basic Plan	2	$698.37	$762.43	9.2%
	(All Ages)	3	$868.17	$947.79	9.2%
ALADS	Prudent Buyer Plan	1	$643.97	$689.89	7.1%
Blue Cross	Premier Plan	2	$1,177.54	$1,263.15	7.3%
	Under Age 50	3	$1,339.94	$1,437.20	7.3%
ALADS	Prudent Buyer Plan	1	$643.97	$689.89	7.1%
Blue Cross	Premier Plan	2	$1,177.54	$1,263.15	7.3%
	Age 50 and Over	3	$1,339.94	$1,437.20	7.3%
ALADS	CaliforniaCare	1	$443.41	$481.29	8.5%
Blue Cross	Premier Plan	2	$781.10	$850.95	8.9%
	(All Ages)	3	$950.90	$1,036.31	9.0%
CAPE	Classic	1	$490.00	$564.90	15.3%
Blue Shield		2	$984.56	$1,095.59	11.3%
		3	$1,221.56	$1,412.62	15.6%
CAPE	Lite	1	$316.00	$335.72	6.2%
Blue Shield		2	$634.56	$698.55	10.1%
		3	$813.56	$905.24	11.3%
CAPE	PPO	1	$484.42	$560.85	15.8%
Blue Shield	(Out-of-state only)	2	$973.45	$1,087.49	11.7%
		3	$1,255.22	$1,402.09	11.7%
FIREFIGHTERS LOCAL 1014		1	$457.00	$496.00	8.5%
		2	$868.56	$942.56	8.5%
		3	$1,030.56	$1,118.56	8.5%

[a] 1 = Employee only
2 = Employee + 1 Dependent
3 = Employee + 2 or more Dependents

[b] Rates reflect current negotiated County subsidies

ENCLOSURES TO EXHIBIT V

1. **ALADS Request**
2. **CAPE Request**
3. **Los Angeles County Firefighters Local 1014 Request**

ENCLOSURE 1

AUG 7 2008

ALADS Insurance Trust

9500 Topanga Canyon Blvd. Chatsworth, CA 91311
Tel (818) 678-0040 (800) 842-6635 Fax (818) 678-0030

August 5, 2008

Mr. Michael J. Henry, Director
County of Los Angeles
Hall of Administration, Room 579
500 West Temple Street
Los Angeles, California 90012

Via U.S. Mail and E-Mail

Attn: Ms. Marian Hall
Human Resources Manager
Employee Benefits – Deferred Income Division
Department of Human Resources
County of Los Angeles
3333 Wilshire Boulevard, Tenth Floor
Los Angeles, California 90010

RE: **ALADS/BLUE CROSS 2009 HEALTHCARE PLAN PREMIUMS**

Dear Ms. Hall:

Following are the monthly premium rates for the ALADS Blue Cross Prudent Buyer and CaliforniaCare medical and dental plans for the 2009 plan year:

Plan	*Employee*	*Employee + 1*	*Employee + 2*
Prudent Buyer Basic	$601.37	$1,180.07	$1,354.12
Prudent Buyer Premier	$689.89	$1,268.59	$1,442.64
CaliforniaCare Basic	$392.77	$ 767.87	$ 953.23
CaliforniaCare Premium	$481.29	$ 856.39	$1,041.75

The ALADS plans do provide "Creditable Coverage" as defined in the Act.

The only Plan change is that for Mental Health/Substance Abuse coverage, the Plan has been amended to provide these coverages through Holman Professional Counseling Centers (HPCC). Attached is an outline of the improved benefits.

Sincerely,

Bud Treece, Trust Administrator

BENEFIT SCHEDULE
Provided by Holman for
ALADS Prudent Buyer Members

BENEFITS	*Holman Prudent Buyer Plan Design*	
Lifetime Maximum	**$5 million**	
Calendar year deductible for all Providers	None	
Emergency Room	10% co-pay	
MENTAL HEALTH[2]	**In-Network**	**Out-of-Network**
Out-Patient	$20 co-pay/visit[5]	$25 /visit paid[5]
Sub-Acute[1]	20% co-pay[3,5]	Not Covered
In-Patient	20% copay[3,5]	Emergency Only 20% co-pay[3,4,5]
Annual Maximum	50 outpatient visits/calendar year[5] 60 sub-acute days/calendar year[3,5] 30 inpatient days/calendar year[3,5]	
Annual Out-of-Pocket Max	**None**	
SUBSTANCE ABUSE[2]	**In-Network**	**Out-of-Network**
Out-Patient	$20 co-pay/visit[5]	$25 /visit paid[5]
Sub-Acute[1]	20% co-pay[3,5]	Not Covered
In-Patient	20% co-pay[3,5]	Emergency Only 20% co-pay[3,4,5]
Annual Maximum	50 outpatient visits/calendar year[5] 60 sub-acute days/calendar year[3,5] 30 inpatient days/calendar year[3,5]	
Annual Out-of-Pocket Max	**None**	
SERIOUS & SEVERE AB88 Diagnoses	**In-Network**	**Out-of-Network**
Out-Patient	10% co-pay	Emergency Only[4] 10% co-pay
Sub-Acute	10% co-pay	Not Covered
In-Patient	10% co-pay	Emergency Only[4] 10% co-pay
Annual Out-of-Pocket Max	$450	$6,000

Serious & Severe AB88 Diagnoses include: Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, Panic Disorder, Obsessive-Compulsive Disorder, Pervasive Disorders (Autism), Anorexia Nervosa, Bulimia Nervosa, Severe Emotional Disturbances of Children (SED).

[1] 60 Days/Calendar year Combined in-network & out-of-network, mental health & substance abuse

[2] Any co-payments made for the treatment of mental or nervous disorders or substance abuse will not be applied toward the satisfaction of the out-of-pocket maximum. In addition, you will be required to pay your co-payment even after reaching the out-of-pocket maximum.

[3] Hospital Maximum of 30 days/year can be exchanged for sub-acute inpatient days on a 2 for 1 basis. One hospital day can be exchanged for two sub-acute, partial hospital or day treatment day.

[4] Holman uses Ingenix Health Intelligence to determine Usual and Customary rates for all out of network providers.

[5] Combined ALL Behavioral In & Out of network, Mental Health & Substance Abuse.

BENEFIT SCHEDULE
Provided by Holman for
ALADS California Care Members

BENEFITS	*Holman California Care Plan Design*	
Lifetime Maximum	Unlimited	
Deductible	None	
Emergency Room	$25 co-pay waived if admitted	
MENTAL HEALTH[2]	**In-Network**	**Out-of-Network**
Out-Patient	$20 co-pay/visit[5]	Not Covered
Sub-Acute[1]	20% co-pay[1,5]	Not Covered
In-Patient	20% co-pay[5]	Emergency Only 20% co-pay[4,5]
Annual Maximum	50 outpatient visits/calendar year[5] 100 sub-acute days/calendar year[1] 30 inpatient days/calendar year[3,5]	
Annual Out-of-Pocket Max	None	
SUBSTANCE ABUSE[2]	**In-Network**	**Out-of-Network**
Out-Patient	$20 co-pay/visit[5]	Not Covered
Sub-Acute[1]	20% coinsurance[1,5]	Not Covered
In-Patient	$0 co-pay[5]	Emergency Only[4]
Annual Maximum	50 outpatient visits/calendar year[5] 100 sub-acute days/calendar year[1] 30 inpatient days/ calendar year[3,5]	
Annual Out-of-Pocket Max	None	
SERIOUS & SEVERE AB88 Diagnoses	**In-Network**	**Out-of-Network**
Out-Patient	$5 co-pay	Not Covered
Sub-Acute	$0 co-pay	Not Covered
In-Patient	$0 co-pay	Emergency Only[4]
Annual Out-of-Pocket Max	$500/member, $1500/Family	

Serious & Severe AB88 Diagnoses include: Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, Panic Disorder, Obsessive-Compulsive Disorder, Pervasive Disorders (Autism), Anorexia Nervosa, Bulimia Nervosa, Severe Emotional Disturbances of Children (SED). Annual Maximum of 100 sub-acute days/calendar year.

[1] 100 Days/Calendar year Combined in-network & out-of-network, mental health & substance abuse;

[2] Any co-payments made for the treatment of mental or nervous disorders or substance abuse will not be applied toward the satisfaction of the out-of-pocket maximum. In addition, you will be required to pay your co-payment even after reaching the out-of-pocket maximum.

[3] Hospital Maximum of 30 days/year can be exchanged for sub-acute inpatient days on a 2 for 1 basis. One hospital day can be exchanged for two sub-acute, partial hospital or day treatment day.

[4] Holman uses Ingenix Health Intelligence to determine Usual and Customary rates for all out of network providers.

[5] Combined ALL Behavioral In & Out of network, Mental Health & Substance Abuse.

ENCLOSURE 2

August 4, 2008

Marian Hall
Human Resources Manager
Employee Benefits-Deferred Income Division
County of Los Angeles
Department of Human Resources
3333 Wilshire Boulevard
Los Angeles, CA 90010

Re: 2009 RENEWAL – CAPE/BLUE SHIELD MEDICAL PLANS

Dear Ms. Hall:

This letter is to advise you of the CAPE Benefit Trust Board of Trustees' approval of the renewal of Blue Shield's contracts for the year 2009 for the CAPE/Blue Shield Point of Service Classic and Lite medical plans, and the out-of-state PPO COBRA medical plan. Attached please find the benefit structures and rates for all three plans.

We have enhanced the wellness, generic prescription drug and out-of-network eye exam benefits for the Classic and Lite plans as follows:

- Added coverage for Periodic Health Exams under the Classic and Lite PPO and Out-of-Network benefit tiers – Classic, $20 copayment under PPO tier/Lite, $25 copayment under PPO tier, neither subject to the deductible; and 60% after deductible under the Out-of-Network tiers.

- Added coverage for Immunizations under the Classic and Lite PPO and Out-of-Network benefit tiers with the same benefit structure as listed above.

- Reduced generic prescription drug copayments under both the Classic and Lite plans to $5.00 if filled by a participating pharmacy and $10 for a 90 day supply by mail order.

1870 West Sunset Boulevard, Suite 800 • Los Angeles, CA 90026-3281 • (213) 484-0100 • Fax (213) 484-1963 • (800) 11

- ☐ Added coverage for annual eye exams under the Classic and Lite under the PPO and Out-of-Network tiers for non-MES providers – up to $60 reimbursement for an ophthalmologist exam and $50 for an optometrist exam.

- ☐ Reduced the office visit copay under the COBRA out-of-area PPO to $20 for immunizations, periodic health exams, doctor office visits and chiropractic care; increased carrier coinsurance to 90% for ambulance, emergency room and hospital care; increased carrier coinsurance to 70% for doctor office visits out of network.

There are no other core benefit changes for 2009 other than any mandated regulatory changes.

We would appreciate your forwarding the 2009 CAPE/Blue Shield medical plans' information to the Board of Supervisors for their timely approval.

Sincerely,

CALIFORNIA ASSOCIATION OF
PROFESSIONAL EMPLOYERS BENEFIT TRUST

John W. Fallon
Chairman
CAPE Benefit Trust Board of Trustees

Attachments

2009 CAPE/Blue Shield
Classic Plan*

(800) 487-3092 www.blueshieldca.com

BENEFITS	PRIMARY CARE NETWORK	PPO NETWORK	OUT-OF-NETWORK (Reimbursements Based On Allowable Amount)
Type of Plan	A Point of Service Plan		
Who is Eligible	All Participants	All Participants	All Participants
Calendar Year Deductible	None	$300 per person; $600 per family maximum (combined-PPO Network and Out-of-Network)	$300 per person; $600 per family maximum (combined-PPO Network and Out-of-Network)
Maximum Annual Out-of-pocket Expenses	$2,000/person; $4,000/family	After deductible, $4,000/person; $8,000/family (combined - PPO Network and Out-of-Network)	After deductible, $6,000/person; $12,000/family (combined - PPO Network and Out-of-Network)
Lifetime Maximum Benefit	Unlimited	$4,000,000 (combined PPO Network/Out-of-Network)	$4,000,000 (combined PPO Network/Out-of-Network)
PREVENTIVE CARE			
Immunizations	100%; no copayment	100% after $20 copayment (not subject to deductible)	60% after deductible
Periodic Health Exams	100%; no copayment (including Well Baby/Well Woman Exam,	100% after $20 copayment (including Well Baby/Well Woman Exam,	60% after deductible (including Well Baby/Well Woman Exam,
	Pap Smear, and Mammography)	Pap Smear, and Mammography-not subject to deductible)	Pap Smear, and Mammography)
Vision Care	Up to age 18 screenings only; 100%; All members one eye	Non-MES Providers-Ophthalmologist exam up to $60 reimbursement/	Non-MES providers-Ophthalmologist exam up to $60 reimbursement/
	exam per year- $10 copayment at MES providers only	Optometrist exam up to $50 reimbursement	Optometrist exam up to $50 reimbursement
MEDICALLY NECESSARY CARE			
Ambulance	100% after $50 copayment	90% after deductible	90% after deductible
Doctor Office Visits	100% after $10 copayment	100% after $20 copayment for consultation only (not subject to deductible)	60% after deductible
Emergency Room	100% after $50 copayment (waived if admitted)	100% after $50 copayment (waived if admitted)	100% after $50 copayment (waived if admitted)
Hospital Care	100%; no copayment	90% after deductible	60% after deductible, carrier max payment $420 per day
Maternity	100%; no copayment	100% after $20 copayment for consultation only (not subject to deductible)	60% after deductible
Surgery	100%; no copayment (outpatient $50 copayment)	90% after deductible	60% after deductible, outpatient-carrier max pymt $420 per day
X-Ray & Lab Tests	100%; no copayment	90% after deductible	60% after deductible
Prescription Drugs	$5 (generic), $15 (brand name), $30 (nonformulary-requires	$5 (generic), $15 (brand name), $30 (nonformulary-requires	Covered emergencies only - copayment applies
	preapproval); Mail-Order- 90-day Supply: $10 (generic),	preapproval); Mail-Order- 90-day Supply: $10 (generic),	
	$30 (brand name), $60 (nonformulary-requires preapproval)	$30 (brand name), $60 (nonformulary-requires preapproval)	
MENTAL HEALTH CARE			
Mental Health-Outpatient	Non-severe psychiatric care: $10 copayment for initial visit;	Non-severe psychiatric care: $10 copayment for initial visit;	Non severe psychiatric care: 50% after deductible (up to 20 combined
	$50 copayment/visit thereafter (up to 20 combined visits	$50 copayment/visit thereafter (up to 20 combined visits	visits per calendar year)
	per calendar year)	per calendar year)	Severe mental illness: 60% (after deductible)
	Severe mental illness: $10 copayment/visit	Severe mental illness: $10 copayment/visit	
	----Provided by United Behavioral Health. Must be arranged through MHSA----		
Mental Health-Inpatient	100%	100%	60% (after deductible), up to $420 carrier max per day
	----Provided by United Behavioral Health. Must be arranged through MHSA----		
OTHER PLAN BENEFITS			
Chiropractic Care	100% after $10 copayment	100% after $10 copayment	Not covered
	----Includes acupuncture; up to 40 combined visits/calendar year (based on medical necessity)----		
	----Provided through American Specialty Health Plans----		
Hearing Aids	$1,000 maximum benefit every two years	Not covered	Not covered
Home Health Care	100% after $10 copayment	90% after deductible	60% after deductible
	(combined 100 visits per calendar year)	(combined 100 visits per calendar year)	(combined 100 visits per calendar year)
Hospice Care	100% when provided by authorized hospice agency	100% when provided by authorized hospice agency	Not covered unless authorized by Blue Shield
Physical Therapy	100% after $10 copayment	90% after deductible	60% after deductible
Skilled Nursing Facility	100%; no copayment (combined 100 days per calendar year)	90% after deductible (combined 100 days per calendar year)	60% after deductible (combined 100 days per calendar year)

*This is a limited benefit summary. Refer to the carrier summary for further details.

In case of discrepancies, the carrier's summary takes precedence.

2009 Premium Rates

Employee Only: $ 564.90

Employee + One: $1,101.03

Employee + Family: $1,418.06

2009 CAPE/Blue Shield
Lite Plan*

(800) 487-3092 www.blueshieldca.com

BENEFITS	PRIMARY CARE NETWORK	PPO NETWORK	OUT-OF-NETWORK (Reimbursements Based On Allowable Amount)
Type of Plan	A Point of Service Plan		
Who is Eligible	All Participants	All Participants	All Participants
Calendar Year Deductible	None	$500 per person; $1,000 per family maximum (combined-PPO Network and Out-of-Network)	$500 per person; $1,000 per family maximum (combined-PPO Network and Out-of-Network)
Maximum Annual Out-of-pocket Expenses	$2,000/person; $4,000/family	After deductible, $4,000/person; $8,000/family (combined - PPO Network and Out-of-Network)	After deductible, $6,000/person; $12,000/family (combined - PPO Network and Out-of-Network)
Lifetime Maximum Benefit	Unlimited	$4,000,000 (combined PPO Network/Out-of-Network)	$4,000,000 (combined PPO Network/Out-of-Network)
PREVENTIVE CARE			
Immunizations	100%; no copayment	100% after $25 copayment (not subject to deductible)	60% after deductible
Periodic Health Exams	100%; no copayment (including Well Baby/Well Woman Exam,	100% after $25 copayment (including Well Baby/Well Woman Exam,	60% after deductible (including Well Baby/Well Woman Exam,
	Pap Smear, and Mammography)	Pap Smear, and Mammography-not subject to deductible)	Pap Smear, and Mammography)
Vision Care	Up to age 18 screenings only; 100%; All members one eye	Non-MES providers-Ophthalmologist exam up to $60 reimbursement/	Non-MES providers-Ophthalmologist exam up to $60 reimbursement/
	exam per year- $10 copayment at MES providers only	Optometrist exam up to $50 reimbursement	Optometrist exam up to $50 reimbursement
MEDICALLY NECESSARY CARE			
Ambulance	100% after $50 copayment	80% after deductible	80% after deductible
Doctor Office Visits	100% after $10 copayment	100% after $25 copayment for consultation only (not subject to deductible)	60% after deductible
Emergency Room	100% after $50 copayment (waived if admitted)	100% after $50 copayment (waived if admitted)	100% after $50 copayment (waived if admitted)
Hospital Care	100%; no copayment	80% after deductible	60% after deductible, carrier max payment $360 per day
Maternity	100%; no copayment	100% after $25 copayment for consultation only (not subject to deductible)	60% after deductible
Surgery	100%; no copayment (outpatient $75 copayment)	80% after deductible	60% after deductible, outpatient-carrier max pymt $360 per day
X-Ray & Lab Tests	100%; no copayment	80% after deductible	60% after deductible
Prescription Drugs	$5 (generic), $15 (brand name), $30 (nonformulary-requires	$5 (generic), $15 (brand name), $30 (nonformulary-requires	Covered emergencies only - copayment applies
	preapproval); Mail-Order- 90-day Supply: $10 (generic),	preapproval); Mail-Order- 90-day Supply: $10 (generic),	
	$30 (brand name), $60 (nonformulary-requires preapproval)	$30 (brand name), $60 (nonformulary-requires preapproval)	
MENTAL HEALTH CARE			
Mental Health-Outpatient	Non-severe psychiatric care: $10 copayment for initial visit;	Non-severe psychiatric care: $10 copayment for initial visit;	Non severe psychiatric care: 50% after deductible (up to 20 combined
	$50 copayment/visit thereafter (up to 20 combined visits	$50 copayment/visit thereafter (up to 20 combined visits	visits per calendar year)
	per calendar year)	per calendar year)	Severe mental illness: 60% (after deductible)
	Severe mental illness: $10 copayment/visit	Severe mental illness: $10 copayment/visit	
	----Provided by United Behavioral Health. Must be arranged through MHSA----		
Mental Health-Inpatient	100%	100%	60% (after deductible), up to $360 carrier max per day
	----Provided by United Behavioral Health. Must be arranged through MHSA----		
OTHER PLAN BENEFITS			
Chiropractic Care	100% after $15 copayment	100% after $15 copayment	Not covered
	----Includes acupuncture; up to 30 combined visits/calendar year (based on medical necessity)----		
	----Provided through American Specialty Health Plans----		
Hearing Aids	$1,000 maximum benefit every two years	Not covered	Not covered
Home Health Care	100% after $10 copayment	80% after deductible	60% after deductible
	(combined 100 visits per calendar year)	(combined 100 visits per calendar year)	(combined 100 visits per calendar year)
Hospice Care	100% when provided by authorized hospice agency	100% when provided by authorized hospice agency	Not covered unless authorized by Blue Shield
Physical Therapy	100% after $10 copayment	80% after deductible	60% after deductible
Skilled Nursing Facility	100%; no copayment (combined 100 days per calendar year)	80% after deductible (combined 100 days per calendar year)	60% after deductible (combined 100 days per calendar year)

*This is a limited benefit summary. Refer to the carrier summary for further details.

In case of discrepancies, the carrier's summary takes precedence.

2009 Premium Rates

Employee Only:	$335.72
Employee + One:	$703.99
Employee + Family:	$910.68

2009 CAPE/Blue Shield
COBRA PPO Plan*

(800) 487-3092 www.blueshieldca.com

BENEFITS	IN-NETWORK	OUT-OF-NETWORK (Reimbursements Based On Allowable Amount)
Type of Plan	A Preferred Provider Option Plan	
Who is Eligible	Participants residing outside the State of California	Participants residing outside the State of California
Calendar Year Deductible	$250 per person; $500 per family maximum (combined-In-Network and Out-of-Network)	$250 per person; $500 per family maximum (combined-In-Network and Out-of-Network)
Maximum Annual Out-of-pocket Expenses	After deductible, $3,000/person; $6,000/family (combined - In-Network and Out-of-Network)	After deductible, $10,000/person; $20,000/family (combined - In-Network and Out-of-Network)
Lifetime Maximum Benefit	$6,000,000 (combined PPO Network/Out-of-Network)	$6,000,000 (combined PPO Network/Out-of-Network)
PREVENTIVE CARE		
Immunizations	$20 copayment per visit (not subject to deductible)	Not covered
Periodic Health Exams	$20 copayment per visit (Includes Well Woman Pap Smear and Mammography/	Not covered
	Well Baby Lab subject to deductible)	
Vision Care (dependent child to age 18)	Screening only-included in Annual Exam copayment	Not covered
MEDICALLY NECESSARY CARE		
Ambulance	90% after deductible	80% after deductible
Doctor Office Visits	$20 copayment for consultation only (not subject to deductible)	70% after deductible
Emergency Room	90% after $50 copayment (waived if admitted)	80% after $50 copayment (waived if admitted)
Hospital Care	90% after deductible	60% after deductible, carrier max payment $600 per day
Maternity	100% after $20 copayment for consultation only (not subject to deductible)	70% after deductible
Surgery	90% after deductible	70% after deductible, outpatient-carrier max pymt $420 per day
X-Ray & Lab Tests	90% after deductible	70% after deductible
Prescription Drugs	$10 (generic), $15 (brand name), $30 (nonformulary-requires preapproval)	Covered for emergencies only- 75% of lesser of actual price or
	Mail-Order 90-day Supply: $20 (generic), $30 (brand name),	reasonable charge, minus copayment
	$60 (nonformulary-requires preapproval)	
MENTAL HEALTH CARE		
Mental Health-Outpatient	Non-severe psychiatric care: $10 copayment for initial visit;	Non severe psychiatric care: 50% after deductible (up to 20 combined
	$50 copayment/visit thereafter (up to 20 combined visits	visits per calendar year)
	per calendar year)	Severe mental illness: 70% (after deductible)
	Severe mental illness: $10 copayment/visit	
	----Provided by United Behavioral Health. Must be arranged through MHSA----	
Mental Health-Inpatient	100%	70% (after deductible), up to $420 carrier max per day
	----Provided by United Behavioral Health. Must be arranged through MHSA----	
Chiropractic Care	$20 copayment - maximum 12 visits per calendar year combined with	40% - maximum 12 visits per calendar year combined with
	Out-of-Network visits	In-Network visits
OTHER PLAN BENEFITS		
Home Health Care	90% after deductible	70% after deductible
	(combined 100 visits per calendar year)	(combined 100 visits per calendar year)
Hospice Care	100% when provided by authorized hospice agency	Not covered unless authorized by Blue Shield
Physical Therapy	90% after deductible	70% after deductible
Skilled Nursing Facility	90% after deductible (combined 100 days per calendar year)	70% after deductible (combined 100 days per calendar year)

*This is a limited benefit summary. Refer to the carrier summary for further details.
In case of discrepancies, the carrier's summary takes precedence.

2009 Premium Rates

Employee Only: $560.85

Employee + One: $1,092.93

Employee + Family: $1,407.53

ENCLOSURE 3

LOS ANGELES COUNTY FIRE FIGHTERS
LOCAL 1014 HEALTH AND WELFARE PLAN
3460 FLETCHER AVENUE · EL MONTE, CALIFORNIA 91731
(310) 639-1014 (800) 660-1014 (within California)

July 17, 2008

Marian Hall
Senior Human Resources Manager
County of Los Angeles
Department of Human Resources
3333 Wilshire Boulevard
Los Angeles, California 90010

In re: 2009 Plan Year Information
Los Angeles County Fire Fighters Local 1014 Health and Welfare Plan

Dear Ms. Hall:

In response to your request, I am providing the following information regarding 2009 plan design and premium changes for the Los Angeles County Fire Fighters Local 1014 Health and Welfare Plan (Plan) that we wish to have included in your letter to the Board of Supervisors. The Plan's Board of Trustees worked with their Mercer consultant to review claim experience, projections and costs. The benefit changes and premium increases were approved by the board at their meeting of July 14, 2008.

The following are the benefit enhancements to the Plan effective January 1, 2009:

- Increase in-network coinsurance from 80% to 90%
- Increase lifetime maximum per individual from $3,000,000 to $4,000,000
- Increase in-network chiropractic visit allowance to Blue Cross contract rate.
- Increase out-of-network chiropractic maximum allowance to $100 per visit
- Include coverage for shingles vaccination under the "Wellness Benefit"
- Cover hearing aids for children through age 19, $1,000 per ear every three years.
- Increase LASIK benefit from $1,000 @ 50% per eye to $1,500 @80%
- Enhance VSP benefit to reimburse frames once every 12 months; increase frame allowance to $175, cover blended multi-focal lenses (progressive);polycarbonate lenses; tints, including photochromics, and anti-reflective coating

Premium rates for the Plan will increase 8.50% for 2009. The actual monthly rates which are rounded to the nearest dollar are as follows:

ENCLOSURE 3

Member Only	$ 496.00
Member + 1 Dependent	$ 948.00
Family	$1,124.00

As always, if you have any questions or concerns, please call me at (800) 660-1014.

Sincerely,

Alfred F. Cain, CEBS
Administrative Manager

Attachment A

Marci Burns
Principal

777 South Figueroa Street, Suite 1900
Los Angeles, CA 90017
213 346 222[illegible] Fax 213 345 2680
marci.burns@mercer.com
www.mercer.com

August 21, 2008

Ms. Marian Hall
Chief of Employee Benefits
County of Los Angeles
3333 Wilshire Boulevard Suite 1000
Los Angeles, CA 90010-4101

Subject:
Summary of 2009 Medical, Dental and Life Renewal Results and Recommendations (Represented Plans)

Dear Marian:

The following letter summarizes the 2009 renewal proposals for medical, dental, and life plans offered to the represented employees of the County of Los Angeles (County), including our analysis, observations and recommendations. The renewal request and negotiation process is outlined in the attached Addendum.

Medical Plans

Overview

For all represented medical plans, the total projected premium increase for 2009 is 8.5%, or $42.3 million over 2008 premiums. This increase includes the cost of several benefit enhancements to the medical and dental plans, which are explained in more detail in the following pages. This compares to an initial renewal increase of 8.7% or $43.3 million. Negotiated reductions to the medical renewals (exclusive of benefit design changes) equate to $2.6 million.

After evaluation of the renewal proposals, Mercer recommends that the County accept the final 2009 renewal increases offered by CIGNA, PacifiCare and Kaiser as outlined in the table below. We believe the renewals are justified for all plans. A summary of key issues, proposal terms and negotiation results are outlined by carrier in the following pages.

	CIGNA	Kaiser Choices	Kaiser Options	PacifiCare
Final 2009 Renewal Action	-3.7%	+7.9%	+9.7%	+10.9%

CIGNA

CIGNA initially proposed a 3.7% reduction in rates for the HMO and the PPO plans combined. CIGNA's rating methodology typically requires a 4% claim fluctuation margin; however, they were able to use a portion of the funds in the County's premium stabilization reserve (PSR), to offset this requirement. Their 2009 rates include a negative 8.0% margin, in order to reduce the funds in the PSR.

The HMO and POS renewals are blended. On a stand-alone basis, the HMO experience would have resulted in a 4.3% decrease to current rates, and the POS rates would decrease by 3.5%. Using blended rates for 2009 means HMO participants will be subsidizing POS participants to a small degree, which is the opposite of what occurred for 2008.

We reviewed the experience on the programs and negotiated with CIGNA on the following issues:

- As in previous years, trend was higher than the County's actual experience, which has been extremely favorable
- The Premium Stabilization Reserve (PSR) is expected to grow to $9.3 million by the end of 2008 or approximately 21% of annual premium; we requested CIGNA use this PSR to further offset the required renewal

The County also requested that CIGNA quote the cost impact to provide preventive care services at 100%, with no copay. CIGNA indicated there would be no rate impact for making this change. Their rationale is that most preventive care services are covered under capitation arrangements, and the non-capitated services affect smaller segments of the population. The Choices population declined to make this change for 2009 because they did not want to make the associated change on the Kaiser plan, where there would have been a cost impact.

CIGNA's final proposal also resulted in a 3.7% decrease. Although they agreed to slightly lower their trend factors, this was offset by updated experience which was not as favorable as prior experience. As a result, CIGNA held their renewal offer the same as the initial proposal.

Our negotiations did result in the following:

- Renewed commitment to try to reduce the PSR to an acceptable level over the next several years; no more than 6% of premium
- 2007 performance guarantee penalties of $165,243 applied to the 2009 rates

The County's financial agreement with CIGNA provides for a year-end reconciliation of premiums, claims and expenses associated with the plan. Surpluses are deposited to the PSR and any shortfall is withdrawn from the PSR to the extent funds are available. The PSR has grown significantly in recent years, as illustrated in the table below:

	2007	2008[1]	2009[1]
Projected Premium	$44,620,581	$43,889,568	$43,330,635
Year-end Premium Stabilization Reserve (PSR)	$8,621,862	$9,328,830	$5,933,410
PSR % of Premium	19.3%	21.3%	13.5%

[1] CIGNA projection; actual year-end balance will vary based on policy year results.

The County will be billed rates at a 3.7% decrease from 2008; if additional premium is needed, CIGNA will use the PSR to fund the plan. We believe it is reasonable for the County to accept CIGNA's offer to subsidize a portion of the 2009 rate action through the PSR, as was done in 2008.

It is our conclusion that CIGNA's final renewal position is justified based on the County's experience.

Kaiser

Kaiser continues to cover the majority of the County-sponsored represented plan members; however, the number has dropped slightly from 61% in 2007 to 59% in 2008.

Kaiser's renewal proposal was a 7.9% increase for the Choices plan and a 9.1% increase for the Options program. Both of these are based on the current plan designs for each group. The lower renewal for Choices is reflective of the higher starting point for 2008 – which included a 1.5% adverse risk load. Kaiser did not include a risk load for 2009.

In an improvement over the last two years, Kaiser provided a more detailed analysis of the renewal drivers – quantifying both the impact of utilization and unit cost changes by and within service categories. Their analysis covered a three year period and will serve as a basis for future renewal evaluations.

Kaiser's renewal was based on the following factors:

- Higher County-specific utilization, in comparison to the health plan
- Kaiser's commitment to continue working with the County and SEIU Local 721 on the cost mitigation goals and objectives
- No additional load to account for its perception of deteriorating risk of the population, as they have done in the prior two years. Note the lower increase for Choices is reflective of the risk load that was included in the 2008 rates.
- 2006 performance guarantee penalties of $296,458 for Options, and $98,949 for Choices

Our negotiations with Kaiser focused on the following areas:

- In 2006 and 2007, Kaiser's year-end results show an accrued surplus of 3.5% and 4.8% respectively, which is over and above the margin built into their rates.
- The County and Local 721's commitment to the cost mitigation goals and objectives and a possible "partnership credit" to be applied to the rates, which had been done several years ago

In addition to the renewal for the current benefits, the County also requested the cost impact to cover preventive care services at 100%, with no copay. Kaiser's final rates including this benefit change resulted in a 0.65% load to the renewal, or an additional $2.2 million for both Options and Choices for 2009.

Another key component of this renewal is the cost of the Wellness programs for 2009, some of which is being paid for by the County and some of it by Kaiser. The Wellness programs include various elements such as participation incentives, communication, administration, a Clinical Services Consultant and reporting. The County and Kaiser agreed to include approximately $215,000 in the Options renewal rates and about $101,000 in the Choices renewal rates for 2009 (0.1% of premium) to partially cover the cost of these programs. Program specifics will be determined by the end of 2008. This is part of a $350,000 budget across all County-sponsored Kaiser plans. Kaiser agreed to 'true-up' actual expenses to this budget in future renewals. Kaiser is funding an additional $220,000 toward the Wellness initiatives across all County represented and non-represented populations.

After several rounds of negotiations with Kaiser, they remained unwilling to reduce their renewal position, in part because of the County's status as a similar sized subscriber group (SSSG), with respect to the Federal government, which limits Kaiser's ability to negotiate with certain groups. We recommend that the County continue to monitor emerging experience for equity in Kaiser's rating gains or losses over several years. Kaiser did

indicate that they would be willing to discuss a self-funded plan for the County of L.A.; and although there isn't sufficient data to determine whether that is a good option for the County at this time, it may be worth considering in the future.

The Options population elected to accept the preventive care benefit enhancements, resulting in a final renewal of 9.7%; however, Choices declined this change, so their renewal remains at 7.9%.

PacifiCare

PacifiCare initially proposed a 12.1% increase for the HMO plan and a 17.8% increase for the PPO plan, based on the following factors:

- Current benefit plan designs
- $192,203 in performance guarantee penalties for 2006 and 2007
- Reduced amount at risk for performance guarantee penalties from 2% of premium to a flat $2.5 million, a difference of over $700,000.
- Inclusion of $112,000 for disease management programs and $50,000 for related communication materials

PacifiCare also provided the cost of additional Wellness programs for 2009, which were estimated at $358,000. These programs include incentives, online Health Risk Assessments, and Telephonic coaching, among other items.

Negotiations with PacifiCare targeted the following areas:

- Credit for their increasing membership
- Increasing their amount at risk for performance guarantee penalties to 2% of premium, as it has been previously
- Increasing their commitment to funding of Wellness program activities

As with the other carriers, we requested the cost impact of covering preventive care at 100%, with no member copay. PacifiCare indicated this would be worth about 0.1% of premium, or an additional $150,000 for both the HMO and PPO plans.

PacifiCare's final renewal offer resulted in a reduction on the HMO increase to 10.5%, for a savings of almost $2.3 million. They were not willing to revise their 17.8% renewal for the PPO plan. The Options population agreed to accept the preventive care enhancements which result in a final renewal of 10.9% overall; 10.6% for the HMO and 17.9% for the PPO.

PacifiCare's final renewal included the following adjustments:

- Updating of more current claims experience and reduced trend
- Agreement to increase the amount at risk for performance guarantees to 2% of premium
- Agreement to fund the Wellness program for 2009, including, telephonic coaching, incentives, Wellness portal, online HRAs, and a specified number of 'lunch and learns'.
- Preventive care copay waivers

We believe that PacifiCare has justified their renewal position and that the County should accept their offer.

Dental Plans

We believe the dental renewals are justified and should be accepted by the County.

DeltaDental PPO

The current Delta plans are guaranteed through 12/31/08, and Delta's initial renewal proposal was for the two year period beginning 1/1/09.

For the PPO plan, the Choices population and Flex/MegaFlex populations are currently rated together and the Options group is rated on its own. In the future, the County's risk pool for Choices and Flex/MegaFlex will be split and separate renewals for each population will apply for 2010. In conjunction with this change, only a one year rate guarantee will apply to the Choices plan; Delta proposed a 3.2% increase on the contract rates and a 0% increase on the billed rates.

For the Options program, Delta proposed a 2.1% increase to the billed rates and a 4.2% increase to the contract rates. Contract rates are guaranteed for two years.

Billed rates are lower than contract rates due to the available stabilization reserve. A portion of the rates will be subsidized by the funds in the premium stabilization reserve at the end of the contract period. This subsidy equates to about 4% of premium for Options over two years and 8% of premium for Choices for one year.

The Options population decided to accept the following benefit enhancements:

- Increase annual maximum to $1,750 across all three network tiers
- Add orthodontia coverage for adults and children; 50% coinsurance subject to a $1,200 lifetime maximum
- Add coverage for dental implants; 50% coinsurance subject to annual plan maximum
- Allow a third covered cleaning if medically recommended

Choices declined to accept any dental benefit changes with a cost impact for 2009.

Delta's renewal proposal includes the following benefit change at no additional cost:

- one additional cleaning for pregnant women

For Options, these changes result in a final increase of 15.1% on the billed rates and 16.9% on the contract rates. These rates are guaranteed for two years. The final Choices renewal is a rate pass on the billed rates for one year, and a 3.2% increase on the contract rates.

DeltaCare USA – DHMO

Delta proposed a 4.0% increase on the DeltaCare USA dental HMO plan, which is primarily based on dental trend and the County's actual utilization. Rates are guaranteed for two years, through 2010.

DeltaCare proposed some minor changes to the fee schedule, including coverage for teeth whitening. Due to Section 125 regulations prohibiting coverage for cosmetic procedures, it is our recommendation that the County exclude coverage for teeth bleaching under the plan.

Safeguard Prepaid Dental

The Safeguard rates are in a guarantee through 12/31/10; however, the billed rates will be slightly lower than the contract rates for 2009 to account for $5,247 in performance guarantee penalties for 2007.

Life and AD&D

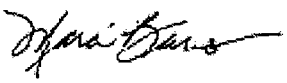
CIGNA Life

The CIGNA Life and AD&D plans are in rate guarantees through 12/31/10; however, due to favorable life experience, we pursued a rate reduction on the optional and dependent life rates for 2009. CIGNA initially agreed to reduce rates by 5%, but further negotiations resulted in a 10% decrease in optional and dependent life rates or approximately $2.5 million in savings.

Although CIGNA did reduce the rates for 2009, we recommend the County consider marketing the life and AD&D for 2010, or as soon as possible thereafter, to ensure that the most competitive rates possible are in place.

If you have any questions or need additional information regarding any of the renewals, please let me know.

Sincerely,



Marci Burns
Principal

Copy
Bill Lynes – County of LA
Bill Scott - Mercer, Los Angeles
Jeff Whitman - Mercer, Los Angeles
Ann Gillespie - Mercer, Los Angeles

Addendum

Process

The renewal request, analysis and negotiation are multi-step processes, conducted over a period of several months. A planning meeting with the County begins the process, in which objectives for the following plan year are established. Stakeholders include the County, Unions (Coalition of County Unions and SEIU-Local 721), Union consultants and Mercer.

Based on the planning meeting discussions, a Request for Renewal (RFR) is drafted and reviewed by all stakeholders. The RFR includes:

- Stated assumptions and requirements, including a submission letter to be signed by a company officer with the authority to bind their proposal
- Questionnaire encompassing carrier financial results, prescription drugs and provider issues, health and productivity management, administration, and quality issues.
- Plan performance exhibits comparing the County's past plan results to the carriers' book of business results
- Rate quotation, rate development and projected cost exhibits
- Benefit design and contract changes
- Performance guarantees

All stakeholders submit requested changes to the draft. These are reviewed and incorporated into the final RFR, which is then released to the carriers.

Carrier proposals are submitted to all stakeholders at the same time. Following a review and analysis period, Mercer drafts negotiation letters for each plan. The drafts are reviewed by the County and the Union consultants, and their respective comments are incorporated before release to the carriers. Weekly status conference calls are conducted between

Attachment B

MERCER

MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

Marci Burns
Principal

777 South Figueroa Street, Suite 1900
Los Angeles, CA 90017
213 346 2221 Fax 213 346 2680
marci.burns@mercer.com
www.mercer.com

August 21, 2008

Ms. Marian Hall
Chief of Employee Benefits
County of Los Angeles
3333 Wilshire Boulevard
Los Angeles, CA 90010

Subject: Summary of 2009 Medical, Dental, and Life Renewal Results and Recommendations (Non-represented Plans)

Dear Marian:

This letter summarizes the results of our analysis and negotiation of the 2009 renewal proposals for medical, dental, and life plans offered to the non-represented employees of the County of Los Angeles (County). In addition, it presents Mercer's recommendations for each plan.

The renewal request and negotiation process is outlined in the attached Addendum.

Medical Plans

Overview

For the non-represented medical plans, the total projected premium increase for 2009 is 8.9% or $8.8 million. This increase includes the cost of several benefit enhancements to the medical plans, which are explained in more detail in the following pages. This compares to an initial increase of 9.2% or $9.1 million for the current plan designs. Negotiated savings, excluding benefit design changes, were almost $1.2 million. The Blue Cross program is self-funded and expected and maximum liability costs are projected. The Blue Cross expected costs are the basis for the renewals outlined in this letter.

After our analysis of the renewal proposals, Mercer recommends that the County accept the final 2009 renewals offered by Blue Cross and Kaiser. A summary of key issues, negotiation results and the proposal terms are outlined below by carrier.

Blue Cross

Blue Cross' initial renewal proposal for the current plan designs, before negotiations, was a 13.7% increase across all plans, or about $8.2 million over 2008. All plans are funded through a minimum premium arrangement with specific stop loss of $300,000 per individual. The aggregate stop loss is currently set at 120% of projected claims for all plans; however, for 2009, the aggregate limit will be 115% for the HMO plan, and 120% for the other plans.

In reviewing Blue Cross' original renewal proposal, we identified several key issues:

- Higher than needed medical trend factors. Blue Cross utilizes book-of-business trend factors for this group. Actual experience for the County has shown a lower trend
- Significant increase in inpatient hospital claims
- Large increase in pooling charges
- No inclusion of a claims credit to offset the cost of the disease management programs, as the experience does not reflect the impact of the program.
- Additional pharmacy rebates that were not reflected in the claims projection

As a result of negotiations, Blue Cross updated their claim projections and lowered their pooling charges and retention, reducing the overall renewal to an 11.5% increase, or a savings of almost $1.1 million based on the current plan designs. Also important to note, the maximum liability on the HMO plan was reduced to 115% of expected claims, as opposed to 120%, which reduced the County's potential liability on this plan.

Additionally, Blue Cross agreed to apply an experience credit to the rate development, offsetting the cost of the disease management programs – 360 Degree Health. The fees, which are included in the retention portion of the renewal rates, amount to about $295,000 for 2009.

Vision benefits for the HMO, POS, and PPO plans are offered on a non-participating insured basis through an arrangement between Blue Cross and VSP. There is also a portion of the vision benefit – coverage for laser eye surgery – which is self-insured by the County. Utilization of the Lasik benefit has been lower than projected, so the equivalent rates for that portion of the vision benefit are decreasing. The overall 2009 vision cost projection for the insured plan and the Lasik coverage is lower than current 2008 costs.

Blue Cross provided their 2007 performance guarantee report and applied the penalty of $329,285 to the County's April 2008 invoice, so there is no direct impact to the renewal.

The County also requested the cost impact for the following benefit changes:

- Covering preventive care services at 100%, with no copay; increasing the claims projection by about $560,000 for 2009.
- Expanding the current VSP network from the value network to the full provider network which would increase the insured portion only of the VSP renewal rates by about 12.2%. The total cost for the vision, even including the network change, is still lower than the 2008 costs.

The County elected to adopt the benefit changes above, which resulted in a final Blue Cross renewal of 12.7%, or $7.6 million over expected costs for 2008. Projected 2009 maximum liability for the Blue Cross plans, including vision, is $77.2 million, based on the current enrollment by product.

We believe Blue Cross' most recent renewal proposal is justified and recommend that the County accept it. However, Blue Cross should continue to work with the County on opportunities to better identify and manage inpatient claims driving the renewal.

Kaiser

Kaiser's renewal for the non-represented plan based on current benefits was a 2.2% increase, or about $856,000 over 2008 costs. Their renewal proposal included the following:

- Higher County-specific trend factors than Kaiser's book of business factors
- Approximately $39,000 included in the rates for Wellness programs
- 2006 performance guarantee penalties of $37,357

In an improvement over the last two years, Kaiser provided a more detailed analysis of the renewal drivers – quantifying both the impact of utilization and unit cost changes by and within service categories. Their analysis covered a three year period and will serve as a baseline for future renewal evaluations.

Our negotiations with Kaiser focused on the following areas:

- In 2006 and 2007, Kaiser's year-end results show an accrued surplus of 3.5% and 4.0% respectively, which is over and above the margin built into their rates.
- Request that Kaiser provide a detailed analysis of the plan's utilization, which we have done in each of the past several years, to support their renewal position.

Another key component of this renewal is the cost of the Wellness programs for 2009, some of which is being paid for by the County and some of it by Kaiser. The Wellness programs include various elements such as participation incentives, communication, administration, a Clinical

Services Consultant and reporting. The County agreed to include approximately $39,000 in the 2009 Flex/MegaFlex rates to partially cover the cost of these programs. This is part of a $350,000 budget across all County-sponsored Kaiser plans. Kaiser agreed to 'true-up' actual expenses to this budget in future renewals. Program specifics will be determined by the end of 2008. Kaiser is funding an additional $220,000 toward the Wellness initiatives across all County represented and non-represented populations.

After several rounds of negotiations with Kaiser, they remained unwilling to reduce their renewal position, in part because of the County's status as a similar sized subscriber group (SSSG), with respect to the Federal government, which limits Kaiser's ability to negotiate with certain groups. We recommend that the County continue to monitor emerging experience for equity in Kaiser's rating gains or losses over several years. Kaiser did indicate that they would be willing to discuss a self-funded plan for the County of L.A.; and although there isn't sufficient data to determine whether that is a good option for the County at this time, it may be worth considering in the future.

There is currently one employee covered by the Kaiser Mid-Atlantic plan, which is community rated and has a standardized plan design. Rates for this plan will increase by 6% for 2009.

The County elected to make a benefit change, waiving copays for preventive care services, which results in a final renewal increase of 3.0%, or $1.15 million. This change does not apply to the Mid-Atlantic plan.

Dental Plans

We believe the dental renewals are justified and should be accepted by the County.

Delta Dental PPO

The current Delta plans are guaranteed through 12/31/08, and Delta's initial renewal proposal was for the two year period beginning 1/1/09.

For the PPO plan, the Choices population and Flex/MegaFlex populations are currently rated together. In the future, the County's risk pool for Choices and Flex/MegaFlex will be split and separate renewals for each population will apply for 2010. In conjunction with this change, only a one year rate guarantee will apply to the Choices plan. Delta proposed a 3.2% increase on the contract rates and a 0% increase on the billed rates.

Billed rates are lower than contract rates due to the available stabilization reserve. A portion of the rates will be subsidized by the funds in the premium stabilization reserve at the end of the contract period. This subsidy equates to about 8% of premium for the one year period.

The County reviewed several plan alternatives and elected to make the following changes for 2009:

- Increasing the annual maximum to $1,760/$1,200/$1,200
- Adding orthodontia coverage for adults and children; 50% coinsurance subject to a $1,200 lifetime maximum
- Add coverage for dental implants; 50% coinsurance subject to annual plan maximum
- Allow a third covered cleaning if medically recommended
- Separating the Flex and Choices populations so they will rated independently going forward

The renewal proposal includes the following benefit change at no additional cost:

- one additional cleaning for pregnant women

These changes result in a final increase of 9.2% on the billed rates and 12.2% on the contract rates. These rates are guaranteed for one year.

DeltaCare USA – DHMO

Delta proposed a 4.9% increase on the DeltaCare USA dental HMO plan which is primarily based on dental trend and the County's actual utilization. Rates are guaranteed for two years, through 2010.

DeltaCare proposed some minor changes to the fee schedule, including coverage for teeth whitening. Due to Section 125 regulations prohibiting coverage for cosmetic procedures, it is our recommendation that the County exclude coverage for teeth bleaching under the plan.

Safeguard Prepaid Dental

The Safeguard rates are in a guarantee through 12/31/10; however, the billed rates will be slightly lower than the contract rates for 2009 to account for $5,247 in performance guarantee penalties (across all plans) for 2007.

Basic Life and AD&D – CIGNA Life

The basic life and AD&D plans are currently in a rate guarantee through 12/31/10.

Survivor Income Benefit

The non-represented optional and dependent life plan was moved from CIGNA Life to MetLife effective 1/1/07. The MegaFlex Survivor Income Benefit portion of the plan was a participating arrangement with CIGNA. CIGNA has performed a final accounting of the plan and determined that a surplus of $755,839 is refundable to the County. Premiums under this policy are shared between the County and plan participants. The County was presented with several options to handle this refund, and the following approach will apply:

- The surplus will be transferred to MetLife and a separate interest bearing account will be established
- The account will be used to buy-down the premium rates for the remaining two years of their rate period, 2009 and 2010.
- Billed rates will be reduced by 10% for the remaining two years while contract rates are continued at the current level. The difference between the two rates is the amount drawn from the fund each quarter, with an accounting given to the County for each quarterly transaction.
- There will likely be some residual funds left at the end of the two years that can be refunded to the County or used as a credit for the renewal rate proposal for 2011.

This approach has the merit of having a third party deal with the accounting transactions. In addition, employee participants will have reduced rates for the next two years, and the "snap back" effect on rates will not be nearly as great with this approach in comparison to other alternatives.

Mercer does not handle the ongoing consulting for the MetLife SIB program, but helped negotiate the terms of the balance transfer.

If you have any questions about the above information, please give me a call to discuss.

Sincerely,

Marci Burrs
Principal

Copy:
Bill Lynes – County of LA
Wayne Willard – County of LA
Jeff Whitman - Mercer, Los Angeles
Ann Gillespie - Mercer, Los Angeles

Addendum

Process

The renewal request, analysis and negotiation are multi-step processes, conducted over a period of several months. A planning meeting with the County begins the process, in which objectives for the following plan year are established. Stakeholders for the Non-represented plan include the County and Mercer.

Based on the planning meeting discussions, a Request for Renewal (RFR) is drafted and reviewed by all stakeholders. The RFR includes:

- Stated assumptions and requirements, including a submission letter to be signed by a company officer with the authority to bind their proposal
- Questionnaire encompassing carrier financial results, prescription drugs and provider issues, health and productivity management, administration, and quality issues
- Plan performance exhibits comparing the County's past plan results to the carriers' book of business results
- Rate quotation, rate development and projected cost exhibits
- Benefit design and contract changes
- Performance guarantees

All stakeholders submit requested changes to the draft. These are reviewed and incorporated into the final RFR, which is then released to the carriers.

Carrier proposals are submitted to all stakeholders at the same time. Following a review and analysis period, Mercer drafts negotiation letters for each plan. The drafts are reviewed by the County, and their comments are incorporated before release to the carriers. Weekly status conference calls are conducted between Mercer and the County to discuss the renewal results, negotiation process and any open issues.

MERCER

MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

Responses to the negotiation letters are due from the carriers prior to the renewal meetings. Again, the responses are delivered to all stakeholders concurrently. Final issues are reviewed and prepared for the renewal meetings.

Two-hour renewal meetings are conducted with each carrier. Attendees include representatives from DHR, CEO and Mercer, as well as the carrier representatives. The carrier representatives generally include account/sales management, financial, operations, and medical/provider relations personnel. Issues discussed during the meetings include: rate development/proposal rates, performance guarantees, RFR deviations, network contracting environment, health promotion programs and quality initiatives. Outstanding issues and requests for reduced rates – where areas of opportunity exist – are identified for each carrier. Following the meeting, carriers must respond to all identified issues in writing to all stakeholders.

The review and negotiation process continues until all open issues are resolved or the carrier has presented their final offer. The negotiation does not always result in agreement on particular topics; however, it may result in overall business concessions from the carriers.

COUNTY OF LOS ANGELES Attachment C

2009 Renewal Results

	2008	2009 Original renewal - current plan	2009 Negotiated renewal - final plan	Percent Change	Negotiation Results	Benefit change impact	Performance Guarantee Credits	Total Change from Original Renewal [1]
Flex/MegaFlex								
Kaiser	$38,182,341	$39,038,285	$39,332,662	3.0%	($56,867)	$351,244	($37,357)	$294,377
Blue Cross [2] Expected Cost	$60,147,511	$68,358,021	$67,781,091	12.7%	($1,136,421)	$559,491	($329,285)	($576,930)
Options								
Kaiser	$206,697,191	$225,530,476	$226,784,792	9.7%	($210,227)	$1,464,543	($206,458)	$1,254,316
PacifiCare	$147,829,206	$166,035,283	$163,911,450	10.9%	($2,274,077)	$150,244	($192,203)	($2,123,833)
Choices								
Kaiser	$98,497,452	$106,396,566	$106,295,149	7.9%	($101,417)	$0	($98,949)	($101,417)
CIGNA [4]	$44,773,794	$43,131,128	$43,120,608	-3.7%	($10,520)	$0	($165,243)	($10,520)
Total Medical	**$596,127,494**	**$648,489,759**	**$647,225,751**	**8.6%**	**($3,789,530)**	**$2,525,522**	**($1,029,495)**	**($1,264,007)**
Delta [4]								
Flex [5]	$8,170,994	$8,712,414	$8,921,918	9.2%	($525,233)	$734,737	$0	$209,504
Options	$32,980,757	$33,746,916	$37,739,285	14.4%	$0	$3,992,369	$0	$3,992,369
Choices [5]	$16,754,429	$17,850,115	$16,823,201	0.4%	($1,026,914)	$0	$0	($1,026,914)
Safeguard [6]								
Flex	$199,922	$200,136	$200,136	0.1%	$0	$0	($316)	$0
Options	$1,984,766	$1,986,831	$1,986,831	0.1%	$0	$0	($3,141)	$0
Choices	$1,130,628	$1,131,854	$1,131,854	0.1%	$0	$0	($1,789)	$0
Total Dental	**$61,221,496**	**$63,628,266**	**$66,803,226**	**9.1%**	**($1,552,147)**	**$4,727,106**	**($5,247)**	**$3,174,959**
CIGNA Basic Life [7]								
Flex/MegaFlex	$41,639	$41,639	$41,639	0.0%	$0	$0	$0	$0
Choices/Options	$1,174,239	$1,174,239	$1,174,239	0.0%	$0	$0	$0	$0
CIGNA Optional Life [7]								
Choices/Options	$24,997,236	$24,997,236	$22,497,512	-10.0%	($2,499,724)	$0	$0	$2,499,724
Total Life [8]	**$26,213,114**	**$26,213,114**	**$23,713,391**	**-9.5%**	**($2,499,724)**	**$0**	**$0**	**$2,499,724**
TOTAL	**$683,562,104**	**$738,331,139**	**$737,742,367**	**7.9%**	**($7,841,400)**	**$7,252,628**	**($1,034,742)**	**$4,410,675**

[1] Reflects changes in total cost due to negotiations and benefit changes

[2] Blue Cross' Performance Guarantee credits were paid directly to the County.

[3] Peformance guarantee penalties were included in the initial renewals for all carriers, except CIGNA.

[4] CIGNA and Delta Dental renewals are based on the billed, subsidized rates

[5] Negotiated savings for Delta Dental represent savings from moving from a 2 year rate guarantee to a 1 year guarantee

[6] Safeguard's premiums are based on billed rates

[7] Basic Life premiums assume rates are guaranteed through 12/31/2010.

[8] Life premiums do not include AD&D plan through CIGNA or the MetLife Optional Life plan for Flex/MegaFlex